

**CHILD CARE CENTERS**  
**RECORDKEEPING ESSENTIALS**  
**of the**  
**CHILD AND ADULT CARE FOOD PROGRAM**



**March 2011**

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Child Care Centers  
Recordkeeping Essentials of the  
Child and Adult Care Food Program

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## **Recordkeeping Requirements for Child Care Centers**

Child care centers receiving payment from the Child and Adult Care Food Program (CACFP) must keep full and accurate records pertaining to the food service operation. The records must be kept to support the claim for reimbursement and to verify that all CACFP requirements are being met. The records to be maintained are detailed below and in Chapter 8 of the CACFP Child Care Center Policy and Procedure Manual available at <http://health.mo.gov/living/wellness/nutrition/foodprograms/cacfp/lawsregs.php>.

All records must be retained for a period of three years after the end of the fiscal year to which they pertain, except that if audit findings have not been resolved, the records shall be retained beyond the end of the three-year period for as long as required for the resolution of the issues raised by the audit. All records must be maintained at the center and must be available for audit by Federal or State officials at all times. Failure to produce required records in a timely manner could result in re-payment to the Missouri Department of Health and Senior Services – Bureau of Community Food and Nutrition Assistance (MDHSS-BCFNA).

Sample forms and completion instructions for each record detailed below are included in this booklet and at <http://health.mo.gov/living/wellness/nutrition/foodprograms/cacfp/appsforms.php>. The institution may use these sample forms or other forms developed by the institution as long as the forms used record the required information.

Required records include:

1. **Copies of all menus.** Menus must be dated for each day and indicate all meals components that were served. Each facility must verify the menu served to the children meets the minimum meal pattern requirement. Write in all substitutions. Menus must be maintained for each meal claimed for reimbursement. Food purchase receipts and invoices will be reviewed to ensure adequate food and milk purchases are made and that the receipts support the menu. See page 8 and 9 for a sample menu form, *Menu – USDA Requirements (CACFP-218)*.

For infants 0 through 11 months old, a separate menu (individual infant meal record) is required. A maximum of two meals and one snack or one meal and two snacks may be claimed regardless of the number of times the infant is fed.

For infants 0 through 3 months, the *Individual Infant Meal Record 0 through 3 months (CACFP-215)* on page 10 is required for each infant. List the actual amounts for formula or breastmilk consumed as well as the time of feeding. Indicate which meals are being claimed (breakfast, a.m. snack, lunch, p.m. snack, supper, or evening snack).

For infants 4 through 7 months old, the *Individual Infant Meal Record 4 through 7 months (CACFP-216)* on page 11 is required for each infant. Circle the foods offered at each meal. The required amounts are listed on this form. It is not required to list the actual amount consumed for this age group.

For infants 9 through 11 months old, the *Individual Infant Meal Record 8 through 11 months (CACFP-217)* on page 12 is required. List the actual foods offered. The required amounts are listed on this form. It is not required to list the actual amount consumed for this age group.

2. **Infant Preference Form – Center** completed by the parent should be on file for each infant in care. Centers that claim meal reimbursement for infants in their care are required to have this form completed and signed by parents of all infants enrolled. Keep this form with each infant’s enrollment record. The purpose of this form is to obtain the parents’ preferences and to determine if the infants’ meals can be claimed for reimbursement. Centers must offer an iron-fortified infant formula that meets the needs of the majority of infants in care. Parents/guardians not wanting their infants to receive the center offered formula may bring infant formula or breast milk from home. However, if the center wishes to claim the infant’s meals, the center must provide all other required meal components as appropriate for age according to the Infant Food Chart. See the Policy and Procedure Manual for Child Care Centers, Sections 5.11 and 7.2 for more information on infant meal requirements. See page 13 of this booklet for a copy of the form *Infant Feeding Preference – Centers*.
3. **Enrollment documents for each child claimed.** All children claimed for reimbursement must be enrolled at the center for care. Each SCCR/CACFP enrollment form must indicate the child’s name, address, phone number, and date of enrollment. In addition, the enrollment form must include the child’s usual hours of attendance at the child care center, the usual days of the week the child is in care, and the meals usually eaten at the child care center while in care. This information must be completed by the child’s legitimate parent or guardian, and must be signed and dated by that person. All enrollment forms must be updated annually. It is required that child care centers use the enrollment form developed by the Department of Health and Senior Services. See page 14-15 for a copy of the *SCCR/CACFP Child Care Enrollment Form (MO 580-2994)*.
4. **Daily attendance records.** Daily attendance records must be maintained for each child. The attendance records **cannot** be used as a basis for completing the meal count record. However, the attendance records must support the meal count records. For example, if John Doe was claimed for a meal on October 17, the attendance records must indicate that John Doe was present on October 17. For the CACFP, you must choose one of these methods for your attendance record:
  - *Attendance Record (CACFP-213)* see page 16,
  - *Time In/Time Out Record (CACFP-221)* see pages 17-18 or
  - *Time In/Time Out Record (CACFP-224)* see pages 19-20.
5. **Meal count records.** Each monthly claim for reimbursement must be supported by dated meal count records for each meal served during the month. A maximum of two meals and one snack or one meal and two snacks may be claimed per child in attendance per day. The meal count record must indicate the daily number of meals served to children by type of meal (breakfast, lunch, supper, or snack). Center personnel must physically record each meal at the time the meal is served to each

child by eligibility category (free, reduced, and paid). Included on pages 21 and 22 of this booklet are instructions and a sample form *Meal Count (CACFP-225)*.

6. **Non-profit food service verification.** All centers must have documentation to verify that all of the CACFP reimbursement is being used solely for the conduct of the food service operation or to improve food service operations. Non-profit food service verification includes:
  - a. Documentation of income to the program. Income to the program includes all monies received from State, Federal, or local government sources, any center funds used to subsidize the food service program, any payments for adult meals, and any other income including loans and donations to the food program.
  - b. Documentation of food purchases. All monthly **food purchase records/receipts** must be maintained to support claims for reimbursement and to document non-profit food service operations. Food receipts will be closely examined to assure that foods purchased match menus for the time-period and to assess the quantity of food purchased. If it is determined that inadequate quantities of food were purchased to meet minimum meal pattern requirements, then meals will be disallowed. For this reason, it is very important that all food receipts are maintained in a central location. Receipts must be dated, itemized, and legible. Do not purchase food from companies that do not provide itemized, dated receipts.
  - c. Documentation of other food service expenditures. Food service expenditures include labor cost **supported by payroll stubs and time studies**, cost of expendable food service equipment, cost of maintaining non-expendable food service equipment, and indirect costs. Included on pages 23-24 of this booklet are instructions and a sample form for documenting food service labor cost *Summary of Salary Expenses (CACFP-214)*.

**Expendable equipment** has a durability of less than two years with a cost of \$500 or less. **Non-expendable equipment** has a durability of two years or more and cost more than \$500. Examples of indirect costs are rent, utilities, office supplies, etc. A portion of indirect costs can be charged to the CACFP if there is documentation available to support the charge.

7. **Income Eligibility Forms (IEFs).** An Income Eligibility Form (IEF) must be on file for each child claimed as free or reduced. IEFs must be updated annually. The IEF is effective on the first day of the month during the month the form is initially signed by the center representative, and expires one year later on the date the center representative signed the form. See the Income Eligibility Guidance booklet at <http://health.mo.gov/living/wellness/nutrition/foodprograms/cacfp/lawsregs.php> for more information on proper completion of the IEF and Section 10 of the CACFP

Child Care Center Policy and Procedure Manual for more information on free and reduced price meals.

Centers are encouraged to maintain a master listing to include:

- a. all enrolled children
- b. the claiming category for each child
- c. the date the Income Eligibility Form (IEF) was signed by center personnel.

Use of the master listing will assist in keeping the IEFs updated on an annual basis. Included on pages 25 and 26 in this booklet are instructions and a sample form *Enrollment Roster (CACFP-220)*.

8. **Title XX documentation or Free/Reduced documentation.** For-profit centers must document monthly their eligibility to participate in the CACFP. For-profit centers must be able to verify that at least 25% of the enrolled children or licensed capacity (whichever is less) are either Title XX beneficiaries or eligible for free and reduced price meal reimbursement. Required documentation is either monthly Family Services Division vendor invoices or current Income Eligibility Forms. See Section 4.4 and 4.5 of the CACFP Child Care Center Policy and Procedure Manual for more information on how to determine Title XX eligibility and Free and Reduced eligibility.
9. **Civil Rights racial/ethnic data.** All centers must:
  - a. display the “And Justice For All” poster;
  - b. provide the nondiscrimination statement and procedure for filing a complaint in all center brochures;
  - c. collect actual beneficiary data by racial/ethnic category (see NOTE); and
  - d. provide informational materials in the appropriate translation regarding the CACFP.

NOTE: Each center must physically count, at least once per year, the number of program participants in attendance by racial/ethnic category. Documentation of this count must be maintained on file. Use the *Beneficiary Data Report (CACFP-226)* included on page 27 of this booklet.

10. **Documentation of training to staff.** The institution must ensure that staff is trained at least annually on CACFP issues. Documentation of training must include:
  - a. session dates
  - b. locations
  - c. topics
  - d. names of participants
  - e. name of presenter

Included on page 28 of this booklet is a sample form *Training Documentation (CACFP-222)*.

11. **Food substitution for medical reasons.** Participants with medical or special dietary needs may have substitutions to the meal pattern only when supporting documentation is on file. The documentation must be signed by a recognized medical authority such as a physician, physician assistant, nurse practitioner, or advanced practice nurse. See Policy 7.5 for more information. Use the form included on page 29 of this booklet *Medical Food Substitution Record (CACFP-227)*.
12. **Miscellaneous documentation.** The following miscellaneous documentation must be retained:
  - a. Child care center license.
  - b. Copies of all supporting documents submitted to the MDHSS-CFNA for application.
  - c. Copies of all correspondence from MDHSS-CFNA or to MDHSS-CFNA.
  - d. Production Records (for centers vended by a Food Service Management Company or Caterer).
  - e. Food Safety and Sanitation Inspection Report.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**MENU – USDA REQUIREMENTS**

NAME OF CENTER/FACILITY \_\_\_\_\_

WEEK OF \_\_\_\_\_

YEAR \_\_\_\_\_

BREAKFAST	DATE	DATE	DATE	DATE	DATE
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Other Foods					
<b>SUPPLEMENT</b> <i>Serve 2 of 4 choices.</i>					
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					
<b>LUNCH</b>					
Fluid Milk					
2 Servings of Fruit and/or Vegetables					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					





MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**MENU – USDA REQUIREMENTS**

NAME OF CENTER/FACILITY \_\_\_\_\_

WEEK OF \_\_\_\_\_

YEAR \_\_\_\_\_

<b>SUPPLEMENT</b> <i>Serve 2 of 4 choices.</i>	DATE	DATE	DATE	DATE	DATE
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
<i>Other Foods</i>					
<b>SUPPER</b>					
Fluid Milk					
2 Servings of Fruit and/or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					
<b>SUPPLEMENT</b> <i>Serve 2 of 4 choices.</i>					
Fluid Milk					
Juice, Fruit, or Vegetable					
Grains/Bread Component					
Meat or Meat Alternate					
Other Foods					



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**INDIVIDUAL INFANT MEAL RECORD**

0 THROUGH 3 MONTHS

INFANT'S NAME		MEALS CLAIMED <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Supper		AGE (MONTHS)	DATE OF BIRTH
CENTER/PROVIDER		BREASTMILK <input type="checkbox"/> YES <input type="checkbox"/> NO		FORMULA TYPE	CLAIM MONTH/YEAR

**CLAIM ONLY APPROVED MEALS**

REQUIREMENTS	DATE		DATE		DATE		DATE		DATE	
	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME	AMOUNT EATEN	TIME
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										
4-6 Oz. Breastmilk or Iron Fortified Infant Formula*										



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**INDIVIDUAL INFANT MEAL RECORD**

**4 THROUGH 7 MONTHS**

INFANT'S NAME				AGE (MONTHS)		DATE OF BIRTH	
CENTER/PROVIDER		BREASTMILK <input type="checkbox"/> YES <input type="checkbox"/> NO		FORMULA TYPE		MONTH/YEAR	
<b>CLAIM ONLY APPROVED MEALS</b>							
<b>REQUIREMENTS</b>		DATE		DATE		DATE	
		<b>Circle or list specific foods consumed by this infant</b>					
<b>BREAKFAST</b>							
Breastmilk or Iron Fortified Infant Formula	4-8 fl. OZ.	Breastmilk Formula Rice cereal Barley	Breastmilk Formula Rice cereal Barley	Breastmilk Formula Rice cereal Barley	Breastmilk Formula Rice cereal Barley	Breastmilk Formula Rice cereal Barley	Breastmilk Formula Rice cereal Barley
Iron Fortified Dry Infant Cereal (when ready)	0-3 Tbsp.	Oatmeal Mixed cereal	Oatmeal Mixed cereal	Oatmeal Mixed cereal	Oatmeal Mixed cereal	Oatmeal Mixed cereal	Oatmeal Mixed cereal
<b>AM SNACK</b>							
Breastmilk or Iron Fortified Infant Formula	4-6 fl. OZ.	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula
<b>LUNCH</b>							
Breastmilk or Iron Fortified Infant Formula	4-8 fl. OZ.	Breastmilk Formula Rice cereal Barley	Prunes Apricots Carrots Grn. Beans	Breastmilk Formula Rice cereal Barley	Prunes Apricots Carrots Grn. Beans	Breastmilk Formula Rice cereal Barley	Prunes Apricots Carrots Grn. Beans
Iron Fortified Infant Cereal (when ready)	0-3 Tbsp.	Oatmeal Mixed cer. Apples	Peas Potatoes Sweet pot.	Oatmeal Mixed cer. Apples	Peas Potatoes Sweet pot.	Oatmeal Mixed cer. Apples	Peas Potatoes Sweet pot.
Fruit and/or Vegetable (not juice) (when ready)	0-3 Tbsp.	Bananas Peaches Pears Other:	Squash Spinach Mixed veg	Bananas Peaches Pears Other:	Squash Spinach Mixed veg	Bananas Peaches Pears Other:	Squash Spinach Mixed veg
<b>PM SNACK</b>							
Breastmilk or Iron Fortified Infant Formula	4-6 fl. OZ.	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula	Breastmilk Formula
<b>SUPPER</b>							
Breastmilk or Iron Fortified Infant Formula	4-8 fl. OZ.	Breastmilk Formula Rice cereal Barley	Prunes Apricots Carrots Grn. Beans	Breastmilk Formula Rice cereal Barley	Prunes Apricots Carrots Grn. Beans	Breastmilk Formula Rice cereal Barley	Prunes Apricots Carrots Grn. Beans
Iron Fortified Infant Cereal (when ready)	0-3 Tbsp.	Oatmeal Mixed cer. Apples	Peas Potatoes Sweet pot.	Oatmeal Mixed cer. Apples	Peas Potatoes Sweet pot.	Oatmeal Mixed cer. Apples	Peas Potatoes Sweet pot.
Fruit or Vegetable (not juice) (when ready)	0-3 Tbsp.	Bananas Peaches Pears Other:	Squash Spinach Mixed veg	Bananas Peaches Pears Other:	Squash Spinach Mixed veg	Bananas Peaches Pears Other:	Squash Spinach Mixed veg



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**INDIVIDUAL INFANT MEAL RECORD**

8 THROUGH 11 MONTHS

INFANT'S NAME		AGE (MONTHS)		DATE OF BIRTH	
CENTER/PROVIDER		BREASTMILK <input type="checkbox"/> YES <input type="checkbox"/>		FORMULA TYPE	
				MONTH/YEAR	
<b>CLAIM ONLY APPROVED MEALS</b>					
<b>List specific foods consumed by this infant. Foods from child menu may be used if infant is developmentally ready</b>					
<b>REQUIREMENTS</b>	<b>8-11 MO</b>	Date	Date	Date	Date
<b>BREAKFAST</b>					
Iron Fortified Infant Formula or Breastmilk	6-8 fl. oz.				
Iron Fortified Infant Cereal	2-4 Tbsp.				
Fruit and/or Vegetable (not juice)	1-4 Tbsp.				
<b>AM SNACK</b>					
Iron Fortified Infant Formula <sup>1</sup> or Breastmilk or Full Strength Fruit Juice	2-4 fl. oz.				
Crusty Bread (optional)	0-1/2 slice				
Crackers (optional)	0-2				
<b>LUNCH</b>					
Iron Fortified Infant Formula or Breastmilk	6-8 fl. oz.				
Iron Fortified Infant Cereal and/or	2-4 Tbsp.				
Meat, Fish, Poultry, Egg Yolk, or Cooked Dry Beans or Peas	1-4 Tbsp.				
or Cheese	1-4 Tbsp.				
or Cottage Cheese, Cheese Food or Spread	1/2 - 2 oz.				
Fruit or Vegetable (not juice)	1-4 oz.				
	1-4 Tbsp.				
<b>PM SNACK</b>					
Iron Fortified Infant Formula or Breastmilk or Full Strength Fruit Juice	2-4 fl. oz.				
Crusty Bread (optional)	0-1/2 slice				
Crackers (optional)	0-2				
<b>SUPPER</b>					
Iron Fortified Infant Formula or Breastmilk	6-8 fl. oz.				
Iron Fortified Infant Cereal and/or	2-4 Tbsp.				
Meat, Fish, Poultry, Egg Yolk, or Cooked Dry Beans or Peas	1-4 Tbsp.				
or Cheese	1-4 Tbsp.				
or Cottage Cheese, Cheese Food or Spread	1/2 - 2 oz.				
Fruit or Vegetable (not juice)	1-4 oz.				
	1-4 Tbsp.				



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**INFANT FEEDING PREFERENCE – CENTERS**

Name of infant \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_ will feed your infant breastmilk provided by you and / or we  
(name of provider)  
will provide iron fortified infant formula.

The formula we provide is: \_\_\_\_\_

Please mark your preference (choose all that apply)	Date _____ Birth – 3 months	Date _____ 4 – 7 months	Date _____ 8 – 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
I want the center to provide formula for my infant.			
I will bring formula for my infant. Please list kind of formula you will bring: _____			

This center is participating in the Child and Adult Care Food Program (CACFP). In order to claim meals for reimbursement, the center must provide infant cereal and other foods when your baby is developmentally ready for them.

Please mark your preference	Date _____ 4 – 7 months	Date _____ 8 – 11 months
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.		
I will bring solid food for my infant when he / she is ready for it.		

First Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Second Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Third Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION / BUREAU COMMUNITY FOOD & NUTRITION ASSISTANCE  
**CHILD CARE ENROLLMENT FORM**

FACILITY/PROVIDER NAME	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
ADDRESS (STREET, CITY, STATE, ZIP)		

**IDENTIFYING INFORMATION**

MOTHER'S/GUARDIAN'S NAME	HOME PHONE
ADDRESS (STREET, CITY, STATE, ZIP) OR CHECK IF SAME AS ABOVE p	CELL PHONE
	E-MAIL
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP)	WORK PHONE
FATHER'S/GUARDIAN'S NAME	HOME PHONE
ADDRESS (STREET, CITY, STATE, ZIP) OR CHECK IF SAME AS ABOVE p	CELL PHONE
	E-MAIL
EMPLOYER OR SCHOOL ATTEND	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP)	WORK PHONE

**EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY  
(OTHER THAN PARENT) AT LEAST ONE EMERGENCY CONTACT IS REQUIRED.**

NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP)		
NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (CELL, WORK, HOME)
ADDRESS (STREET, CITY, STATE, ZIP)		

**COMMENTS ON CHILD'S DEVELOPMENT**

(NOTE CHILD'S PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, AND INDIVIDUAL NEEDS)


**RELATED CHILD**

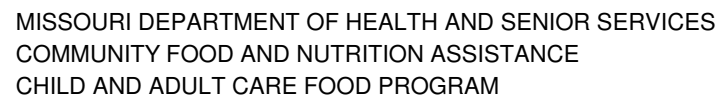
<input type="checkbox"/> YES <input type="checkbox"/> NO	HOW IS CHILD RELATED TO CHILD CARE PROVIDER?
--	--

**CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED**

CHECK HERE WHAT DAYS THE CHILD WILL ATTEND. WILL CHILD ATTEND: <input type="checkbox"/> Full Time or <input type="checkbox"/> Part Time		WHAT TIME DOES YOUR CHILD USUALLY ARRIVE EACH DAY? CIRCLE AM OR PM.	WHAT TIME DOES YOUR CHILD USUALLY LEAVE EACH DAY? CIRCLE AM OR PM.	WRITE ANY COMMENTS, CHANGES OR VARIATIONS IN USUAL ATTENDANCE IN THIS SECTION INCLUDING SHIFT CHANGES.
MON		AM PM	AM PM	
TUES		AM PM	AM PM	
WED		AM PM	AM PM	
THURS		AM PM	AM PM	
FRI		AM PM	AM PM	
SAT		AM PM	AM PM	
SUN		AM PM	AM PM	

PLEASE ALSO COMPLETE PAGE 2.

CACFP REQUIREMENT	<b>CHECK THE MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY</b>			
	<input type="checkbox"/> BREAKFAST <input type="checkbox"/> MORNING SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> AFTERNOON SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVE SNACK <input type="checkbox"/> NONE			
	<b>CHECK THE HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY</b>			
	<input type="checkbox"/> NEW YEAR'S DAY (JANUARY)	<input type="checkbox"/> MARTIN LUTHER KING JR.'S BIRTHDAY (JANUARY)	<input type="checkbox"/> PRESIDENT'S DAY (FEBRUARY)	<input type="checkbox"/> EASTER (MARCH/APRIL)
	<input type="checkbox"/> MEMORIAL DAY (MAY)	<input type="checkbox"/> INDEPENDENCE DAY (JULY)	<input type="checkbox"/> LABOR DAY (SEPTEMBER)	<input type="checkbox"/> COLUMBUS DAY (OCTOBER)
	<input type="checkbox"/> VETERANS DAY (NOVEMBER)	<input type="checkbox"/> ELECTION DAY (NOVEMBER)	<input type="checkbox"/> THANKSGIVING (NOVEMBER)	<input type="checkbox"/> CHRISTMAS DAY (DECEMBER)
	<b>AUTHORIZATION FOR EMERGENCY MEDICAL CARE</b>			
	I UNDERSTAND THAT I WILL BE NOTIFIED AT ONCE IN CASE OF AN EMERGENCY WITH MY CHILD, AND I WILL MAKE ARRANGEMENTS FOR MEDICAL CARE OF MY CHILD WITH THE PHYSICIAN OR HOSPITAL OF MY CHOICE.			
	IF I CANNOT BE REACHED TO MAKE NECESSARY ARRANGEMENTS, OR IN A CRITICAL EMERGENCY REQUIRING MEDICAL CARE, I AUTHORIZE  <div style="text-align: center; margin-top: 20px;">           _____            DAY CARE CENTER OR HOME PROVIDER         </div>			
	TO CONTACT THE FOLLOWING:			
<b>PHYSICIAN OR CLINIC</b>				
NAME			PHONE	
<b>PREFERRED HOSPITAL</b>				
NAME			PHONE	
<b>TRANSPORTATION TO AND FROM SCHOOL</b>				
I <input type="checkbox"/> (DO) OR <input type="checkbox"/> (DO NOT) GIVE PERMISSION FOR THE FACILITY TO TRANSPORT MY CHILD TO AND FROM SCHOOL.				
NAME OF SCHOOL CHILD ATTENDS:				
<b>ACKNOWLEDGEMENTS</b>				
A	I HAVE RECEIVED A COPY OF THIS FACILITY'S POLICIES PERTAINING TO THE ADMISSION, CARE AND DISCHARGE OF CHILDREN.		PARENT/GUARDIAN INITIALS _____	
B	I HAVE BEEN INFORMED THAT A COPY OF THE LICENSING RULES FOR CHILD CARE HOMES OR THE LICENSING RULES FOR GROUP CHILD CARE HOMES AND CENTERS IS AVAILABLE AT THIS FACILITY FOR REVIEW.		PARENT/GUARDIAN INITIALS _____	
C	THE PROVIDER AND I HAVE AGREED ON A PLAN FOR CONTINUING COMMUNICATION REGARDING MY CHILD'S DEVELOPMENT, BEHAVIOR AND INDIVIDUAL NEEDS.		PARENT/GUARDIAN INITIALS _____	
D	WHEN MY CHILD IS ILL, I UNDERSTAND AND AGREE THAT S/HE MAY NOT BE ACCEPTED FOR CARE OR REMAIN IN CARE.		PARENT/GUARDIAN INITIALS _____	
E	I UNDERSTAND THAT, BEFORE THE FIRST DAY OF ATTENDANCE BY MY CHILD, I WILL PROVIDE PROOF OF COMPLETED AGE-APPROPRIATE IMMUNIZATIONS OR EXEMPTION FROM IMMUNIZATIONS.			
F	I UNDERSTAND THAT I MUST GIVE WRITTEN PERMISSION FOR FIELD TRIPS/EXCURSION AND THAT I WILL BE NOTIFIED, IN ADVANCE, WHEN THEY ARE PLANNED.			
PARENT'S/GUARDIAN'S SIGNATURE ▶ _____			DATE _____	
CACFP REQUIREMENT	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE	
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE	
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE	



## DAILY ATTENDANCE RECORD

MO 580 1461 (8-05)

Enter this number in field (6) of the online claim .

CACER 212



**Instructions for Completing Time In/Time Out Record**  
**Option A – Time In/Time Out Record (CACFP-221)**

Option A uses one page for each day. All children's names are on the same page/pages listed alphabetically by last name.

1. Enter day of the week.
2. Enter calendar date indicating month, day, and year.
3. List the enrolled children (in alphabetical order with last name first).
4. Indicate in the "time in column" the time the child arrives at the child care center and the initials of the person who enters the time.
5. Indicate the time the child leaves the child care center and the initials of the person who enters the time.
6. Total the number of hours attended each day.



DATE \_\_\_\_\_

MO 580-1457 (6/04) CACFP-221

**Instructions for Completing Time In/Time Out Record**  
**Option B – Monthly Attendance Time In/Time Out Record (CACFP-224)**

Option B uses one page for each child. Sheets are kept in a three ring binder notebook. New names can be added and old names removed as necessary. Each letter of the alphabet or each family name has its own tab making it easier to locate.

1. Enter the month and year.
2. Enter the child's name.
3. Enter the date of the week.
4. Enter the time the child arrives at the child care center.
5. Enter the time the child leaves the child care center.
6. Total the number of hours attended each day.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 COMMUNITY FOOD AND NUTRITION ASSISTANCE  
 CHILD AND ADULT CARE FOOD PROGRAM  
**MONTHLY ATTENDANCE TIME IN/TIME OUT RECORD**

CHILD'S NAME \_\_\_\_\_

MONTH \_\_\_\_\_

YEAR \_\_\_\_\_

	MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
<b>WEEK OF</b>	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
<b>WEEK OF</b>	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
<b>WEEK OF</b>	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
<b>WEEK OF</b>	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
<b>WEEK OF</b>	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										
<b>WEEK OF</b>	IN	OUT	IN	OUT	IN	OUT	IN	OUT	IN	OUT
HOURS ATTENDED										

## **Instructions for Completing Meal Count Form (CACFP-225)**

The meal count must be recorded at the time of the meal service. Center personnel must maintain a point of service meal count, which means that each meal is recorded on the meal count record as the meal is served to each child, or within a very short period of time thereafter. Meals that are not recorded on the meal count records within the time-frame of the meal service may not be claimed for reimbursement. A total head count or head count by category is not sufficient.

Meal count records may also record the eligibility category (free, reduced, or paid) of the child. Care should be taken to assure there is no overt discrimination in the classification and identification of children eligible for free or reduced priced meals. Centers who record eligibility classifications on the meal count records should use a code to distinguish between the free, reduced and paid.

1. Enter the calendar date, showing month, day, and year in appropriate spaces.
2. List enrolled children (preferably in alphabetical order with last name, first name).
3. For each child, indicate claiming category under the code box using a code that assures confidentiality such as:

X: Free category  
Y: Reduced category  
Z: Paid category
4. For each meal served, place a check mark under the appropriate meal type.
5. Calculate the total free meals, total reduced meals, and total paid meals for each meal category, across and down. Compare the across calculations with the down calculations to check for accuracy.

Meal Count Forms for seven-day operations are available at  
<http://health.mo.gov/living/wellness/nutrition/foodprograms/cacfp/appsforms.php>.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**MEAL COUNT**

CENTER	WEEK OF	KEY B-Breakfast, 1-1 <sup>st</sup> Snack, L-Lunch, 2-2 <sup>nd</sup> Snack, S-Supper
--------	---------	---

PARTICIPANT'S NAME	CODE	MONDAY					TUESDAY					WEDNESDAY					THURSDAY					FRIDAY					TOTALS				
		DATE					DATE					DATE					DATE					DATE									
		B	1	L	2	S	B	1	L	2	S	B	1	L	2	S	B	1	L	2	S	B	1	L	2	S	B	1	L	2	S
Total Meals Coded X																															
Total Meals Coded Y																															
Total Meals Coded Z																															

## **Instructions for Documenting Non-Profit Food Service**

1. Save all food receipts and invoices. Nonfood expenditures can be charged to the food service if the nonfood product is necessary to the food service. Examples of allowable nonfood charges include paper napkins, straws, plastic utensils, cleaning supplies for the kitchen, etc.

Only those foods used for the CACFP can be charged to the food service. Food items such as coffee cannot be counted toward the CACFP food service costs.

2. Determine the total amount of food and nonfood costs. If this amount is less than the CACFP monthly reimbursement, document food service labor costs. If the amount of food cost for the month is greater than the CACFP reimbursement, the center does not need to document labor costs.
3. The attached form, *Documentation of Non-profit Foodservice CACFP-214*, will assist in documenting all food service costs and determining the amount of labor cost attributable to the food service. Each position used for the food service should be listed. For each position, indicate:
  - a. The number of people in the position;
  - b. The salary per hour;
  - c. The number of hours spent on the food service; and
  - d. The total cost chargeable to the food program.

Labor cost charges must be supported by payroll stubs and time studies.

4. Determine the amount of income for the food program. Income to the food program can include monies received from state, federal, or local government sources, any center funds used to subsidize the food program, any payments for children's or adult's meals, and donations of food, supplies, equipment, or cash to the food program.
5. Add together the food costs, nonfood costs, and labor costs. Compare this amount to the monthly CACFP reimbursement plus income to the program. If the CACFP reimbursement and income are greater than food service costs, contact MDHSS-CFNA for further instructions.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM

**DOCUMENTATION OF NON-PROFIT FOODSERVICE**

FACILITY NAME						CLAIM MONTH	
POSITION TITLE/EMPLOYEE	SALARY PER HOUR	X	HOURS WORKED PER DAY ON FOOD SERVICE	X	DAYS WORKED PER MONTH	=	SUB TOTALS
		X		X		=	
		X		X		=	
		X		X		=	
		X		X		=	
		X		X		=	
		X		X		=	
		X		X		=	
		X		X		=	
		X		X		=	
<b>TOTAL LABOR COST</b>						=	

INDIRECT COSTS	AMOUNT	X	PERCENT OF FOODSERVICE USEAGE OR PERCENT OF FOODSERVICE SQUARE FOOTAGE	=	SUB TOTALS		GRAND TOTAL SPENT ON CACFP	
		X		=		TOTAL FOOD COSTS (MAINTAIN RECEIPTS)		
		X		=				
		X		=		TOTAL LABOR COSTS		
		X		=		TOTAL INDIRECT COSTS (IF APPLICABLE)		
<b>TOTAL INDIRECT COSTS</b>					=		<b>GRAND TOTAL =</b>	



### **Instructions for Completing Enrollment Roster (CACFP-220)**

The *Enrollment Roster CACFP-220* is not a required record, however, will assist the center in tracking new enrollments and eligibility categories. The Enrollment Roster should be completed on an annual basis. Any new enrollees throughout the year can be added to the bottom of the list.

1. List all children enrolled at the center for child care (preferably in alphabetical order with last name, first name).
2. Indicate the child's claiming category (free, reduced, or paid).
3. Indicate the date when the child was enrolled.
4. Indicate the date when the IEF was signed by the center personnel.
5. Indicate the date when the child was terminated from the child care facility.



Page \_\_\_\_\_ of \_\_\_\_\_

MO 580-1462 (5-04)							CACFP-220




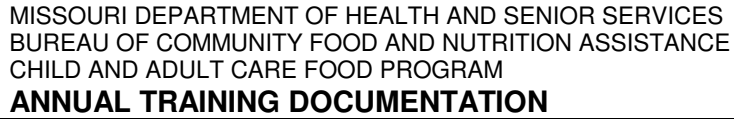
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
BUREAU OF COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**BENEFICIARY DATA REPORT**

A Beneficiary Data Report must be completed once a year to report the racial/ethnic category of participants enrolled in your center. Determine the participant's racial/ethnic category visually using your best judgement. A participant may be included in the category to which he or she appears to belong, identifies with, or is regarded as a member of by the community.

NAME OF CENTER/FACILITY:

ADDRESS:

<b>Ethnic Category</b> (Evaluate all participants for ethnicity first)	<b>Number of Participants</b>
<b>Hispanic, Latino or Spanish origin</b> – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.	
<b>Racial Category</b> (Evaluate all participants for race. Individuals may be counted in one or more categories)	<b>Number of Participants</b>
<b>American Indian or Alaskan Native</b> – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.	
<b>Asian</b> – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
<b>Black, African American or Haitian</b> – A person having origins in any of the black racial groups of Africa.	
<b>Native Hawaiian or Other Pacific Islander</b> – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
<b>White</b> – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.	
<b>Total number of participants evaluated.</b>	
SIGNATURE OF DIRECTOR 	DATE



## Attendance Sign-In

CACFP-222

\*Training must include instruction, appropriate to the level of staff experience and duties, on Program requirements. Attach a copy of the training outline/lesson plan to this form.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
COMMUNITY FOOD AND NUTRITION ASSISTANCE  
CHILD AND ADULT CARE FOOD PROGRAM  
**MEDICAL FOOD SUBSTITUTION RECORD**

The Child & Adult Care Food Program Requirements for Meal Pattern Substitutions Section 7.5 require food substitutions to be authorized by a recognized medical authority. Recognized medical authority includes physician, physician assistant, or nurse practitioner. The recognized medical authority must specify, in writing, the food to be omitted from the patient's diet and the food or choice of foods that may be substituted.

PATIENT'S NAME:

MEDICAL DIAGNOSIS / REASON:

SPECIAL ASSISTANCE/EQUIPMENT REQUIRED:

**FOOD SUBSTITUTION LIST:**

Fluid Milk	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Meat & Meat Alternative (e.g., eggs, cheese peanut butter, dry bean, yogurt, etc.)	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Bread, Cereal or Whole Grain Products	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)
Fruit & Vegetables or Juice	Allowed Substitutes	Texture (e.g., cut up, ground mince, puree, liquidity)

Additional Dietary Concerns and/or Required Equipment or Assistance Needed:

I (medical authority) certify that the above patient must be provided a special diet or requires special accommodations as indicated above.

SIGNATURE

TITLE

DATE